Health Reform Implementation Council Public Meeting
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Medicaid Reform

Oral Testimony presented by:
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Dear Members of the Illinois Health Reform Implementation Council,

I am Dee Ann Ryan, the Executive Director of the Vermilion County Mental Health 708 Board. I am also the Chairperson of the Children's Mental Health Committee of the Association of Community Mental Health Authorities of Illinois (ACMHAI). Community mental health authorities share with the state a strong interest in assuring outcome based, cost effective community services for people with serious mental illness, substance abuse issues and developmental disabilities. We wish to assist the state by offering input, participating in designing the behavioral healthcare and integrated care systems, and participating in ongoing problem solving and system refinement to ensure that systems are more responsive to the needs the people in our communities.

Today, I am anxious to testify on behalf of the 20% of Illinois youth-including both children and adolescents- who are estimated to have diagnosable emotional or behavioral disorders, and in particular, the 9% to 13% of Illinois youth who are estimated to have serious emotional disturbances that substantially interfere with or limit their functioning in family, school, or community activities. With the escalating enrollment in managed care plans that has occurred during the past decade across the country, youth with emotional and behavioral disorders and their families are increasingly being served in mental health care systems that have adopted managed health care approaches directed at controlling service utilization and containing costs. The subgroup of youth with serious emotional disorders poses the greatest challenge for managed care systems, because these youth require a broad range of services at varying levels of intensity for extended periods of time. In addition, managing the care of these children often requires coordination across multiple systems, including mental health, substance abuse, child welfare, juvenile justice, and education.

During the past decade, there has been a great deal of progress throughout the country in the implementation and financing of systems of care, primarily in the public sector, for children with the most serious needs. State Medicaid programs increasingly have been used to fund these more coherent service-delivery systems. The early and periodic screening, diagnosis, and treatment (EPSDT) program, a prevention program for Medicaid-eligible children up to age 21,

expanded the opportunity to use Medicaid funds to support a broad array of services necessary for the treatment and support of children and adolescents with emotional disorders and their families. Many states have developed local care management entities to insure that children receive community based treatment based upon interagency planning encompassing family and community norms.

Some cautions, as Illinois now moves toward changes in our public funded systems are that these children with serious disorders may be underserved. Most often, there is little incentive in a managed care system to serve the high utilizers of services-those who are the most expensive to serve. For children and adolescents with serious and complex problems, underservice within the behavioral health care system would likely result in shifting the responsibility for providing and funding their care to other more restrictive and more expensive systems such as child welfare or juvenile justice.

The loss of an interagency focus is another concern. Interagency planning at the system level and interagency service planning for individual children are both integral aspects of systems of care. Both of these elements could be lost if they are not directly incorporated into managed care plans, requests for proposals, and contract requirements for managed care organizations and local service providers. Another serious concern is that families of children and adolescents will have less input in the decisions about services for their own children, and less input in the planning and operation of the systems. Further, the needs of culturally diverse children and families often receive less attention under managed care systems, with fewer nontraditional providers, less outreach, and fewer services such as transportation and translation, which often enable individuals to use needed health care services.

I believe that this healthcare reform implementation initiative offers us an opportunity to partner in refining the design of a more cost effective, community based, integrated and family friendly system of care for our children with serious emotional disturbance. Myself and other ACMHAI members would like to work with this council and other system planners to shape the design and implementation of the children's behavioral healthcare system to insure that any system developments or system management contracts include provisions for such features as a broad array of behavioral health services for children and adolescents, interagency service planning, flexible and individualized care, family involvement, and cultural competence. We want to ensure that resources are reinvested in building and expanding much needed service capacity in behavioral health services, that a dedicated process is adopted to plan and manage services for children and adolescents with serious emotional disorders and to develop strategies to provide services to children and adolescents who are not Medicaid eligible, but who are dependent upon the public sector for their care. Additionally, we want to offer our input into capturing data and methodologies for establishing appropriate capitation and case rates, as well as adequate risk-adjustment

strategies to minimize incentives for under-serving children and adolescents and to protect providers from undue financial risk. Finally, we advocate for conducting research and ongoing, systematic evaluation on the effects of the system impact and on individual outcomes through systems such as Total Clinical Outcomes Management (TCOM) developed by our well known Dr. John Lyons.

In closing, several community mental health authorities are ready and willing to partner with the state to develop infrastructure pilots for this challenging group of high cost Medicaid beneficiaries to demonstrate that system of care principles and true community based care can be provided more economically, more child and family friendly, integrated better across all child serving systems, more accountable and with better outcomes.

Thank you for allowing me to speak and to offer our assistance.